STATE OF ARKANSAS

Department of Finance and Administration

Employee Benefits Division
www.ARBenefits.org
This form must be returned to your Health Insurance Representative; not EBD.

State Employees
Enrollment Form

1. Employee Information: (please print)				❒ I decline coverage for myself
Last Name	First Name	MI	Gender	❒ Married ❒ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Work #:	
†Primary Care Physician:	PCP #	Current patient?		

2. Dependent Coverage Information:* ❒ I decline coverage for my dependents**				
SPOUSE	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:		
	†Primary Care Physician:	PCP #	Current patient?	
DEP 1*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 2*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 3*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 4*	LAST NAME	FIRST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	

3. I Wish To Enroll In The Following Plan:

A. Select your level of coverage:	**B. Select your plan option:**
❒ Employee Only	❒ ARHealth - Health Advantage Network
❒ Employee & Spouse	❒ ARHealth - NovaSys Network
❒ Employee & Children	❒ ARHealth HDPPO - NovaSys Network
❒ Family	

† ARHealth does not require you to select a Primary Care Physician (PCP) but it is highly recommended. By coordinating your personal health care through a single physician, you can help maintain a consistent level of service with a provider that understands your medical needs and situation.

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**

**** To be completed for dependents 19 - 24 only. Please submit proof of student status.**

***** Social Security # is not required to add newborn to coverage.**

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒ Yes ❒ No
2) If Yes, what type of coverage? ❒ Medical ❒ Medicare, HIC # _____
If Medicare: Part A Effective Date / / or Part B Eff Date / /
If Medicare: Reason for Coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By Agency Insurance Representative

Agency #:	Name of Agency:	
Employee #:	Hire Date:	Effective Date of Coverage:
If employee is transferring from another agency/district, please provide name:		

I have reviewed this Enrollment Form and believe that the requested action is in accordance with the EBD Benefits Administration Manual.

Agency Insurance Rep. Signature: _____

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) That my eligibility and/or the eligibility of any covered dependents may be audited by EBD, or other designated party, at any time. (7) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly obtains health coverage when not eligible for coverage, presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, repayment for plan losses/claims, or loss of health coverage for life.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ **Date:** _____

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